STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	04/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 19, 2017 through April 25, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 survey sample size was 20. Abbreviations/definitions used in this report are as follows: DON - Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN-Licensed Practical Nurse; CNA - Certified Nurse's Aide; NHA - Nursing Home Administrator; CAA - Care Area Assessment Summary/part of the MDS assessment which assists in identifying and planning for potential problem care areas; eMAR - electronic medication administration record; Hx/hx - history; IDT - Interdisciplinary Team/professionals from different fields and departments who work together with the resident to develop and implement an individualized plan of care; MDS - Minimum Data Set/standardized assessment forms used in nursing homes; PCC - Point Click care/electronic documentation system used for medical records; r/t - related to; e.g-for example; PPD - skin test to check for tuberculosis; Dementia - loss of mental functions such as	F000		

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Dr Cecile Zeringue Adm	Electronically Signed	05/17/2017

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F000	Continued From page 1 memory and reasoning that is severe enough to interfere with a person ' s daily functioning; Bipolar - mood disorder with periods of sadness and excitement; Depression -mood disorder with feelings of sadness; Paranoia - extreme fear or distrust of others; Psychoactive medication - drug used to change brain function to change mood, perception or consciousness; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; Restasis - eye drops that help the eyes natural ability to increase tear production; Alphagan - drops to reduce eye pressure; %-percent; cornea-the transparent front part of the eye; Cul de sac-a pouch that is made using the lower lid of the eye; Ativan-medicine for anxiety; Depakote-medication for seizures, migraines and mental disorders; Anxiety-feeling of nervousness or worry; Tuberculosis-serious infection usually in the lungs; Artificial tears-lubricant for the eye.	F000		
F281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F281	A. E11 was immediately in-serviced on correct eye drop administration for R20, R17, R34 and R 38. B. All Resident's who receive eye drops have the potential to be affected by incorrect administration. Nursing staff were in-serviced by the DON on 5-3-17 on correct eye drop administration. See attachment A C. The eye drop administration policy has been updated to reflect the recommendation of the American Society of Ophthalmic Registered Nurses. The new	6/23/17

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F281	Continued From page 2 Based on record review, observations, interviews and review of other facility documents, it was determined that the nursing staff failed to administer eye drop medications to four (R17, R34, R38 and R40) of the 20 Stage 2 sampled residents in accordance with the facility policy and acceptable nursing clinical standards of practice. Findings include: The facility policy, entitled Eye Drops, last revised January 2007, states to, Separate lids gently with thumb and fingers of the left hand. In separating lids, pressure is exerted on cheek and brow. Draw lower lid down gently; instruct Resident to look upward. Hold the dropper in a horizontal position and drop the solution on the center or toward outer angle of the inverted lid. Never drop solution on cornea. The American Society of Ophthalmic Registered Nurses recommended practice for administration of eye drops (dated August 2013) states to: Gently retract the lower lid. Instill a drop into the cul-de-sac. Avoid application of a drop directly on the cornea. Retracting the lower eyelid creates a pocket into which medications can be instilled. 1. During observation of medication administration on 4/21/17 at approximately 7:40 AM, E11 [RN] was observed instilling an eye drop of Artificial Tears directly into each of R40's eyes using only one hand to pull up upper lid and the same hand to hold the eye drop bottle - without drawing the lower lid down and not instilling the drop onto the inverted lower lid per facility policy and practice standard. 2. During observation of medication administration on 4/21/17 at approximately 7:50 AM, E11 (RN) was observed instilling an eye	F281	policy is posted in the Medication Rooms. See attachment B The Nurse Orientation Checklist has also been updated to include eye drop administration. See attachment C D. The DON/ ADON/ RNAC will observe eye drop administration by three different nurses across shifts daily until 100% compliance has been achieved for three consecutive observations. Then observation will occur three days a week until 100% compliance has been achieved for three consecutive observations. Then observation will occur weekly until 100% compliance has been achieved for three consecutive observations. Then observation will occur monthly until 100% compliance has been achieved for 2 consecutive months. at the end of the three consecutive months there is 100% compliance we will conclude the practice has been successfully correct and will submit final report to the QAPI team.	

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F281	Continued From page 3 drop of Alphagan 0.1% directly into each of R17's eyes using only one hand to pull up upper lid and the same hand to hold the eye drop bottle - without drawing the lower lid down and not instilling the drop onto the inverted lower lid. 3. During observation of medication administration on 4/21/17 at approximately 8:05 AM, E11 was observed instilling an eye drop of Artificial Tears directly into each of R38's eyes using only one hand to pull up upper lid and the same hand to hold the eye drop bottle - without drawing the lower lid down and not instilling the drop onto the inverted lower lid. 4. During observation of medication administration on 4/21/17 at approximately 8:16 AM, E11 was observed instilling an eye drop of Restasis 0.05% directly into each of R34's eyes using only one hand to pull up upper lid and the same hand to hold the eye drop bottle - without drawing the lower lid down and not instilling the drop onto the inverted lower lid. The above findings were reviewed with E2 (DON) on 4/25/17 at 10:25 AM. The above findings for examples 1 through 4 were confirmed with E11 during an interview on 4/25/17 at 11:10 AM. These findings were discussed with E1 (NHA) and E2 on 4/25/17 at 12:00 PM during the exit conference.	F281		
F329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each residents drug regimen must be free from unnecessary drugs. An unnecessary drug	F329	A. The E-Mar for R3 was corrected on 4-25-17 to include monitoring for anxiety and behavior disturbance, by DON. The E-Mar for R26 was corrected to include monitoring for insomnia by the DON on 4-25-17.	6/23/17

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F329	Continued From page 4 is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 2 (R3 and R26) of the 20 Stage 2 sampled residents the facility failed to	F329	B. All Residents on psychoactive drugs have the potential to be affected by insufficient monitoring to ensure effectiveness of medications and lowest possible therapeutic dosing. All Residents on psychotropic medications have been reviewed by the DON and the RNAC to ensure adequate monitoring is in place. C. The Policy and procedure for psychoactive drugs has been updated to include the Residents will be reviewed on admission, quarterly and with psychotropic medication changes to ensure adequate monitoring is in place. This is the responsibility of the DON, ADON and RNAC. All nurses will be in-serviced on this policy by 6-23-2017. See attachment D D. All Residents on psychoactive medications have been reviewed and monitoring is in place. At the beginning of each month, quarterly and on admission a review will be conducted to ensure adequate monitoring is in place by the DON, ADON or RNAC. This will be on going and reported at QAPI meeting. See attachments E,F and G	

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F329	Continued From page 5 ensure behavior/symptom monitoring was conducted for psychoactive medication use. Findings include: 1. The following was reviewed in R3's clinical record: 7/12/16 - Care plan for psychotropic drug use related to diagnosis of depression, anxiety and bipolar disorder including the approaches; monitor the effectiveness of medication or side effects and document all episodes of inappropriate behavior. March and April 2017 - Physician order sheet and eMAR included Ativan twice a day for anxiety and Depakote sprinkles twice a day for dementia with behavioral disturbances. 3/4/17 - 5:28 PM progress note "...but does have episodes of confusion/paranoia related to dementia and mental health diagnosis...". Review of the record lacked evidence of behavior monitoring for anxiety and behavior disturbances. 4/21/17 - 2:33 PM interview with E8 (RN) revealed that s/he could not find behavior monitoring for R3. 4/24/17 - 10:42 AM interview with E9 (RN) revealed s/he could not find behavior monitoring in the record and added that R3 presents with paranoia and becoming aggressive with angry outbursts towards staff. 4/24/17 - 11:00 AM interview with E2 (DON) revealed that behavior monitoring for R3 could not be found.	F329		

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F329	Continued From page 6 4/25/17 - Behavior monitoring approaches were noted to have been added to the eMAR. 2. The following was reviewed in R26's clinical record: 8/23/16 - Care plan for potential risk for insomnia with a goal that the resident will sleep 6-8 hours per night. Approaches included to observe and report sleep patterns. March and April 2017 - Physician orders sheets and eMAR included the use of a hypnotic medication every night for sleep. In April an anti-depressant to assist with sleep was added and the hypnotic dose was lowered in an attempt to discontinue. Review of the record lacked evidence of monitoring of sleep/insomnia. 4/21/17 - 2:35 PM interview with E8 (RN) revealed that sleep should be charted in the progress notes. After the interview progress notes were reviewed again by the surveyor and sleep documentation was not identified. 4/24/17 - 11:00 AM interview with E2 lacked any additional information on sleep monitoring for the use of a hypnotic. 4/24/17 - Sleep monitoring was added to the eMAR. These findings were reviewed with E1 (NHA) and E2 during the exit conference on 4/25/17 at 12:00 PM.	F329		
F441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F441	A. E7 received an x-ray on 4/28/17 which was negative for active disease.	6/23/17

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F441	Continued From page 7 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident	F441	B All Residents have the potential to be affected by not ensuring all new hires have a two step Mantoux test or Chest x-ray on hire. C. Upon review it was discovered that E7 has a history of being a positive reactor to the Mantoux test and was determined to be symptom free through a symptom screening. As E7 had been employed at Jeanne Jugan Residence for several years prior to her LOA the orienting nurses did not want to expose her to unnecessary radiation. The Tuberculin Testing Policy for employees has been reviewed and updated and going forward, all personnel who are considered a new hire, regardless of previous history will receive a two step mantoux test or a chest x-ray. See attachment H D. New orientation files will be kept in the DON's office and will not be filed until determined to be complete by the DON and Human Resource Director. The DON and the Human Resource Director will review all personnel files for completeness each month prior to filing with all staff records. In order to ensure compliance this procedure will be conducted at the completion of each orientation/ testing period until 100% compliance has been achieved with 10 new employee records. Then monthly reviews will be conducted on an ongoing basis by the DON and HR.	

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F441	Continued From page 8 under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide evidence of required two step PPD testing for one (E7) out of 5 sampled employees. Findings include: Review of facility documents revealed: 4/24/17 - The facility returned the provided spreadsheet of randomized employees with the requested two step PPD testing dates. E7 (CNA) was documented as having a hire date of 2/21/17, however did not have documentation of a two step PPD test step done upon hire. During an interview on 4/25/17 at 10:05 AM with E2 (DON) it was confirmed that the facility did	F441		

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F441	Continued From page 9 not perform a two step PPD nor could they provide evidence of a chest x-ray, for E7 because she was a former employee who left in November of 2016 to visit another country then returned and was re-hired on 2/21/17. Review of the employee list documented E7 hire date as 2/21/17 and E7 underwent new hire drug testing as if she was a new hire. These findings were reviewed with E1 (NHA) and E2 on 4/25/17 at 12:00 PM during exit conference.	F441		
F463 SS=E	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and a staff interview, it was determined that the facility failed to ensure call bells were functioning properly in resident areas on the Holy Family Unit. This deficient practice was evident for 1 (room 113) of 10 resident rooms and 2 of 2 shower/tub rooms during observations on at least two days of the survey. Findings include: Surveyor observations revealed: -On 4/20/17(8:50 AM), 4/21/17 (11:56 AM), and	F463	A. E10 immediately removed the hook from room 113 and the tub room and and unwrapped the call bell cord from around the grab bar. B. All Resident have the potential to be affected by call bell cords that can not be pulled. Signs have been posted in the tub and shower rooms to remind Residents and staff to leave the call bell cord to dangle and not to wrap them around bars anything which will interfere with the call bell cords functionality. See attachment I C. A root cause analysis was conducted in an effort to determine who placed the hooks for the call cord and wrapped the cord around grab bars. The Residents themselves reported wrapping the cords around grab bars. We were unable to determine where the hooks came from. Signs have been posted to remind staff and Residents to leave call bell cords to dangle freely. Housekeeping, Maintenance, Nurses and C.N.A's will be in-serviced about leaving call cords to dangle freely by their immediate supervisors.	6/23/17

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F463	Continued From page 10 4/24/17 (8:15 AM), the surveyor observed the call bell cord was attached to a hook on the wall in the bathroom of room 113. The call bell did not function when the cord hanging below the hook was pulled on three separate occasions. -On 4/21/17 (at approximately 11:58 AM) and on 4/24/17 (8:01 AM) in the shower room, the surveyor observed that the call bell cord by the shower was wrapped several times around the grab bar and was not functional when pulled below the grab bar on two occasions. - On 4/21/17 (12:03 PM) and 4/24/17 (8:55 AM), the surveyor observed that in the tub room on the Holy Family Unit the call bell cord by the toilet was on a hook. The call bell did not function when the cord hanging below the hook was pulled on two occasions. On 4/24/17 at 9:01 AM, the surveyor and E10 (LPN-Nursing Supervisor) went to the tub room and shower room and both observed that the call bells were not functional when pulled as described above. In addition, the surveyor discussed the call bell issue in room 113 with E10. E10 stated that he/she would address the findings immediately. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/25/17 at 12:00 PM.	F463	D. The DON and the RNAC will check the tub and shower rooms and 6 random Resident rooms Monday thru Friday for two weeks until 100% compliance has been maintained on all consecutive checks. Then the DON and the RNAC will check the tub and shower rooms and 6 random Resident rooms three days a for a week until 100% compliance has been maintained on all consecutive checks. Then the DON and the RNAC will check the tub and shower rooms and 6 random Resident rooms monthly until 100% compliance has been maintained for three consecutive months. We will then conclude the practice has been successfully completed. Findings will be reported to the QAPI team for evaluation.	

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence **DATE SURVEY COMPLETED: April 25, 2017**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 **3201.1.0** **3201.1.2**	**The State Report incorporates by references and also cites the findings specified in the Federal Report.** An unannounced annual survey was conducted at this facility from April 19, 2017 through April 25, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 survey sample size was 20. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of the Regulation, as fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**, Cross Refer to the CMS 2567-L survey Completed April 25, 2017: F281, F329, F441 and F463.	Cross refer to CMS 2567-L survey Completed April 25, 2017: F281, F329, F441 and F463.	

Provider's Signature Dr Cecilo Zeringue Title adm. Date 5/17/17